Long Term Care Highlights

North Dakota Department of Health
Division of Health Facilities

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Inside this issue:

Special points of interest:

- Learn some valuable hand hygiene hints.
- Guidance recommending alcohol-based hand gels in health care settings.
- One in ten older people suffer from an anxiety disorder.
- MDS Section I Disease Diagnosis Urinary Tract Infections have changed.

Hand Hygiene Hints

By Cindy LaBere, R.N.

Transmission of health care associated pathogens from one resident to another via the hands of a health care worker (HCW) requires the following sequence of events: (1) organisms present on the resident's skin, or shed onto inanimate objects in close proximity to the resident, must be transferred to HCW hands; (2) organisms must be capable of surviving at least several minutes on HCW hands; (3) hand washing or hand antisepsis by HCW must be inadequate or omitted entirely; (4) contaminated HCW hands must come in contact with another resident or objects used by the resident.

- Hand washing or the use of an alcohol-based hand rub is, without a doubt, the most effective way to help prevent the spread of organisms.

- When a health care worker's hands are visibly dirty or contaminated, he or she should wash with soap and water. Alcohols are not appropriate for use when hands are visibly soiled.

- Gloves reduce hand contamination by 70 percent to 80 percent, prevent cross-contamination, and protect residents and health care workers from infection. Using gloves does not eliminate the need for hand hygiene. Likewise, the use of hand hygiene does not eliminate the need for gloves.

- Hand rubs should be used before and after contact with each resident just as gloves should be changed before and after contact with each resident.

Alcohol-based hand rubs significantly reduce the number of microorganisms on skin, are fast acting, and cause less irritation and dryness than soap and water hand washing.

When using an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. The ideal volume of product to use is unknown, but it is likely that if hands feel dry after they are rubbed together for 10 to 15 seconds, an insufficient volume was used. Note that the volume needed to reduce the number of bacteria on hands varies by product.

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***Hand Hygiene Hints** (continued)*

- Because alcohol-impregnated towelettes contain a limited amount of alcohol, their effectiveness is comparable to soap and water.
- Allergic contact dermatitis due to alcohol hand rubs is uncommon. However, with increasing use of such products, it is likely that true allergic reactions occasionally will occur.

Accessible and convenient dispensing of alcohol-based hand sanitizers is critical to improve compliance. Have alcohol-based hand rubs readily available at the entry to resident's room, at the bedside, in pocket-sized containers to be carried by health care workers, and in other convenient locations.

The above guidelines should not be construed to legalize product claims that are not allowed by an FDA product approval. This information was developed through the Centers for Disease Control and Prevention, along with the Society for Healthcare Epidemiology of America (SHEA), the Association of Professionals in Infection Control and Epidemiology (APIC), and the Infectious Diseases Society of America (IDSA).

Source: "New Guidelines for Hand Hygiene in Health Care Settings."

www.srhd.org/CA/epi/epigram/200211-Epigram.pdf

Hand Hygiene in Food Service

By Laura Hiebert, L.R.D., Health Facilities Surveyor

While the CDC recently issued guidance recommending alcohol-based hand gels as a suitable substitute for hand washing in health care settings[1], these recommendations do not apply to food service settings.

The pathogens predominately present in health care settings differ from those found in food services settings. In health care settings, the most common pathogens are nosocomial bacteria and lipophilic viruses. Food service establishments usually face a different set of fecal pathogens including enteric, non-lipophilic viruses and protozoan oocysts[2].

In addition, there are differences in the types of soil found on the hands of food services workers as compared to health care workers. Due to the nature of their work, it is highly likely that food service workers hands would be soiled with proteinaceous or fatty residues. Proteinaceous materials are known to interfere with the activity of alcohol-based hand gels. Fatty substances can coat pathogens, protecting them from the action of hand gels. Fatty and proteinaceous materials can be effectively removed from hands with the use of soap, running water and friction.

Finally, alcohol-based hand gels are drugs. Constituents of alcohol-based hand gels, including emollients and perfumes, used in food service must be approved as indirect food additives.

1. Centers for Disease Control and Prevention, CDC Guideline for Hand Hygiene in Healthcare Settings, Morbidity and Mortality Weekly Reports, Oct. 25, 2002.

2. FDA/CFSAN, FDA Fact Sheet on Hand Hygiene in Retail and Food Service Establishments, May 2003

Anxiety: Recognition and Management in the Elderly

By Nancy Gordon, L.C.S.W., Health Facilities Surveyor

Which choice best describes a resident with a diagnosis of Anxiety?

1. Verna never leaves her room to attend activities. She always has an excuse and claims she is a private person. She seems to be nervous around large groups.
2. Loren is constantly asking the nurses to check his oxygen tank. He worries his tank will run out and he won't be able to breathe. Thinking about being unable to breathe often leads him into a panic attack.
3. Ethel complains several times a day of stomach problems. She rarely leaves her room because she is afraid of being too far away from a bathroom.
4. Gene worries about everything on a daily basis and never seems happy.
5. All of the above.

If you answered all of the above, you are correct! There are many types of anxiety and many different ways anxiety presents itself in the elderly. This article will focus on four manifestations of anxiety in the elderly and some non-pharmaceutical care options to help you with an anxious resident.

Resident 1 (Verna) represented a resident with the phobic disorder agoraphobia (a fear of public places/crowds). Agoraphobia is not a common disorder in the elderly, but phobic disorders usually manifest in childhood and continue throughout the life span if interventions are not obtained. A phobic disorder involves a persistent, unrealistic, intense anxiety stimulated by a situation, person or object. A phobia such as agoraphobia can inhibit social interaction and lead to isolation.

Resident 2 (Loren) could be experiencing panic disorder – an intense fear or discomfort leading to a panic attack. A panic attack is a sudden onset of extreme anxiety and fear that is accompanied by physical symptoms such as shortness of breath and/or chest pains.

Resident 3 (Ethel) represents a person with a medical condition such as irritable bowel syndrome who is afraid or anxious to be away from her room in case she needs to use the bathroom. Her IBS may be controlled and she may not have had an emergency for ages, but the anticipatory fear of losing control drives her anxiety and forces her to stay in her room.

Resident 4 (Gene) represents generalized anxiety disorder or GAD. This disorder is characterized by six months or more of almost daily anxiety and worry about everything. It affects up to 5 percent of elderly people [1]. It is typical for the elderly person with GAD to have many physical symptoms such as fatigue and headaches. They often seek out physicians to care for symptoms of a psychological origin.

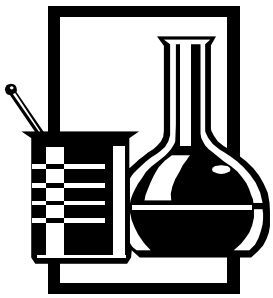
According to some studies, one in 10 older people suffer from an anxiety disorder (www.latelifedepression.org). A study conducted in the Netherlands in 1998 found GAD was the most common anxiety disorder in people ages 55 to 85 [3]. However, most seniors with anxiety disorders have had problems for many years. Stressors such as chronic disease, cognitive impairment, and emotional loss may exacerbate the anxiety to an unmanageable level.

Anxiety. . . (continued)

How To Recognize Anxiety

Recognizing anxiety in older people is a challenge. Aging results in a higher prevalence of medical conditions and realistic thoughts about health problems. Co morbid conditions such as depression and dementia further muddy the diagnostic process. "An anxiety disorder should be considered in any older patient with depressive symptoms or with physical symptoms not explained by a medical condition. These symptoms may be chest pain, shortness of breath, diarrhea, headaches, or sleep problems. A physician should suspect anxiety as the cause of physical symptoms if the symptoms have lasted for two years or more with little change."[3] Gathering a good mental health history on admission from the resident, family and medical professionals can assist you with monitoring the mental status of your residents.

A recent topic in anxiety research is the possibility that what has previously been diagnosed as agitation in Alzheimer's disease and other dementias may be anxiety. Anxiety may manifest in dementia residents as extreme frustration, fear of losing control, restlessness or verbal/physical behaviors. Some question the capacity for anxiety in the cognitively impaired; however, the diagnosis shifts from relying on what the patients say to the behavior they exhibit. It is estimated that about 50 percent of patients with dementia have at least one co-existing medical illness. About one-fourth of these patients will experience some improvement of behavior and cognition with treatment of the underlying disorder. Anxiety is reported to affect up to 40 percent of subjects with dementia. The rate increases with age and is also higher among nursing home residents (www.mayo.edu).



Other conditions may mimic anxiety or be mistaken for an anxiety disorder. Delirium often produces anxiety and agitation, especially if the patient is in unfamiliar surroundings. Depression also may produce symptoms of anxiety and agitation. Anxiety can be a normal part of life if it is due to a legitimate fear of a debilitating illness, mortality or imminent danger. It is important to remember anxiety alerts us to threats and provides the physiological need for action. If it occurs when there is no threat or if it is more intense than is considered normal, then it should be defined as a problem for the resident.

Non-Pharmaceutical Treatment

Many residents with anxiety in the long term care environment have very little interventions in place other than medication. Few residents receive the intense psychotherapy that is needed to invoke change in a faulty thought process. The first person to notice anxious behavior of a resident in long term care may be a nursing assistant, activity person or social worker. All disciplines should be aware of potential interventions for a resident with anxiety so they can effectively cope with problems that may develop. The following questions may help identify anxiety in your residents: [2]

- Have you been concerned about a number of things?
- Is there something going on in your life that makes you worry?
- Do you have a hard time putting something out of your mind?
- What were you doing when you noticed the (chest pain, nausea, etc…)?
- What were you thinking about when you became short of breath?
- When you can't sleep, what are you thinking about?

It is important to evaluate and eliminate items in the resident's everyday operations that may contribute to anxiety. For example, caffeine may be a contributing factor. Caffeine can be found in coffee, tea, soda, chocolate, cold medications and

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Anxiety. . . *(continued)*

some herbal preparations. Also, remove environmental stimuli from the immediate area if it is determined to be the trigger of the anxiety.

Cognitive-behavioral therapy is a therapeutic technique that can be adapted for use in the long term care setting. This is a combination of cognitive therapy – the elimination of negative thought processes and behavioral therapy—the attempt to change behavior. Utilizing this approach, a staff member would teach a resident that typical thoughts such as "that terrible feeling is getting worse!" or "I can't breathe!" can be replaced with substitutes such as "it's only an uneasy feeling – it will pass," a mental statement that will help reduce anxiety and prevent panic. Another method of cognitive change would be to redirect the resident's fearful thoughts to pleasant or mundane thinking, such as counting to 100.

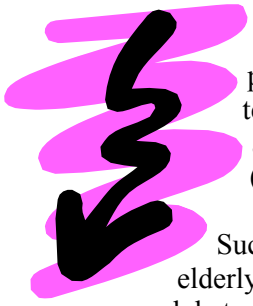
The behavioral portion may involve training in relaxation techniques such as visualization, meditation or breathing techniques. By learning to relax, the resident may acquire the ability to minimize anxiety. Another important aspect of behavioral therapy is real-life exposure. The staff member and the resident determine what places or situations the resident avoids and work on the avoidance behaviors that most isolate the resident; for example, attending group activities. The resident would approach a feared situation gradually, attempting to stay as long as he or she could despite rising anxiety levels. Through this technique, the resident sees the situation is not dangerous, and the frightening feelings will pass. It is important to return the resident to a comfortable environment when he or she requests and to go at the pace of the resident.

Some residents may benefit from a form of "talk therapy" in which the staff member and the resident work together to discover emotional conflicts that may produce anxiety. It is often difficult to find the exact words to assist residents when they are experiencing anxiety. The following phrases obtained from the anxiety panic resource files may assist you with your task:

- "Stay in the present – It's not the place that's bothering you, it's the thought."
- "I know what you are feeling is painful, but it is not dangerous. You are courageous."
- "Tell me what you need." "I am proud of you –you can do it no matter how you feel."

It is important to avoid the following statements: relax, calm down, don't be anxious, don't be silly, you have to stay, don't be a coward.

An important component to stress reduction/relaxation techniques is calming your breath. Natural breathing as described in the anxieties.com website is slowly inhaling a normal amount of air through the nose, feeling your stomach expand, and then exhaling easily. Teaching a resident how to take slow, deep breaths may seem simplistic, but it is imperative that residents with respiratory-related anxiety or panic disorder develop this skill before a problem arises. The best time to teach any technique is during a non-anxious period (anxieties.com/meditation).



Success in dealing with anxiety in the elderly depends upon a consistent approach between the resident, facility staff, family and physician. Everyone needs to agree on the problem and the type of treatment to be utilized. There are a variety of resources on the Internet, some of which have been included in this article.

SOURCES

www.anxieties.com
www.algy.com/anxiety (the anxiety panic internet resource)
www.mayo.edu/geriatrics-rst/Behav.html (Mayo Clinic Rochester)
merck.com/pubs/mmanual (the Merck Manual of Geriatrics)
www.adaa.org/aboutADAA/newsletter/AnxietyandAging.htm
www.latelifedepression.org

1. Blazer, Dan, "Anxiety Disorders," The Merck Manual of Geriatrics, Sec. 4, Chapter 34.
2. Lang, Ariel J., & Stein, Murray B.; "Anxiety Disorders: How to Recognize and Treat the Medical Symptoms of Emotional Illness." Geriatrics, 2001 May, 56(5), 24-27, 31-34.
3. Sampson, Stephanie; "New Thinking on Anxiety and Aging: Anxiety Disorders Common in the Elderly," www.adaa.org.

MDS Coding Clarifications

By Patricia Rotenberger
State RAI Coordinator

The Centers for Medicare & Medicaid Services published a new MDS 2.0 user's manual in December 2002 that became effective Jan. 1, 2003. The new manual contains all of the questions and answers that were separate documents prior to this publication. The answers are listed as clarifications.

The new manual is expanded to include information about MDS automation, reimbursement, quality monitoring applications, clarifications, additional uses of the MDS, attestation statement of accuracy, SNF Medicare PPS Assessment Schedule, MPAF form, and factors impacting SNF Medicare schedule.

There are new flowcharts and assessment schedules in the manual clarifying the timing of the MDS, grace days, and RAP and care plan completion dates.

The new clarifications for all sections of the MDS should make coding easier for all of you. Please note Section I: Disease Diagnosis Urinary Tract Infections. The requirements in this section have changed and are more stringent.

Section M: Skin Conditions includes a reminder that staff should code healing ulcers on the MDS using reverse-staging protocol. There is a new section titled "What is a Pressure Ulcer" that contains valuable information.

If you have any clinical questions regarding coding of the MDS, feel free to call Pat Rotenberger at 701.328.2364.

If you have changed your e-mail address, please notify Bruce Pritschet at bpritsch@state.nd.us.

Visit us at www.health.state.nd.us

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